



BryanLGH Heart Institute

1600 S. 48th Street Suite 600 • Lincoln, NE 68506 • Phone 402/483-3333 • Fax 402/483-3334

AUTHORIZATION FOR REQUEST OR RELEASE OF MEDICAL INFORMATION

(Please Print)

Patient's Legal Name: _____

Patient's Nickname: _____ Age / DOB: ____/____/____ years

Address: _____

City, State, Zip Code: _____ Phone Number: (____) _____ - _____

Records to Request or Release:

- | | |
|---|--|
| <input type="checkbox"/> Complete Cardiology Record | <input type="checkbox"/> Lab and X-ray Report |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Doppler Report |
| <input type="checkbox"/> History and Physical Examination | <input type="checkbox"/> Cath/PTCA Report |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> X-ray Films |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Cine Films |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Operative Report | _____ |
| | _____ |
| | _____ |

Reason for Release:

- | |
|--|
| <input type="checkbox"/> To update my Primary Care Provider |
| <input type="checkbox"/> I have been referred to another physician |
| <input type="checkbox"/> I want/need a second opinion |
| <input type="checkbox"/> I am changing doctors due to: |
| <input type="checkbox"/> Insurance Change |
| <input type="checkbox"/> Dissatisfaction with care |
| <input type="checkbox"/> Moving to a new address |
| _____ |
| _____ |
| Other: _____ |

Date(s) of Service: ____/____/____

I understand that BryanLGH Heart Institute may refuse health care services to me if I fail to sign an authorization if the treatment is for research purposes.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it, by following the procedures provided for in BryanLGH Heart Institute's Notice of Privacy Practices. This authorization will automatically expire after six (6) months from the date it is signed.

This authorization gives my permission and consent to **REQUEST**, from the following described facility, those medical records and test results checked above regarding medical treatment and care that I have received at such facility:

Name _____
 Address _____
 City, ST, Zip _____
 Phone / Fax _____

OR

This authorization gives my permission and consent to **RELEASE** those medical records and test results checked above regarding medical treatment and care that I have received from BryanLGH Heart Institute to the following:

TO

Name _____
 Address _____
 City, ST, Zip _____
 Phone / Fax _____

Mail or Fax To:
Bryan LGH Heart Institute
1600 South 48th Street Suite 600
Lincoln, NE 68506
Fax: 402-483-3334

I understand that BryanLGH Heart Institute is not responsible for uses or disclosures of my medical information by the above party and that there is the potential for such party to further disclose my medical information in a way that it would no longer be protected by privacy laws.

Date

Signature of Patient/Authorized Representative

Date Completed: ____/____/____

Physician Signature of Consent